Subject to the approval of the Task Force

Minutes
HEALTH CARE TASK FORCE
August 27, 2007
9:00 a.m. to 5:30 p.m.
JR Williams Building, East Conference Room
700 W. State Street, Boise, Idaho

The meeting was called to order by **Cochairman Gary Collins** at 9:05 a.m. Other members present were Cochairman Senator Dean Cameron, Senator Joe Stegner, Senator John Goedde, Senator Patti Anne Lodge, Senator Tim Corder, Senator John McGee, Senator Elliot Werk, Representative Sharon Block, Representative Carlos Bilbao, Representative Fred Wood, Representative Jim Marriott, Representative Margaret Henbest and Representative John Rusche. Legislative Services Office staff members present were Eric Milstead and Toni Hobbs.

Others present included Julie Taylor, Karen Early, Jack Myers and Dave Hutchins, Blue Cross of Idaho; Corey Surber, St. Alphonsus; Therese Bishop and Jim Pinkerton, Regence/Blue Shield; Crystal Ross and Kent Kunz, Idaho State University; Norm Varin, Primary Health; Julie Robinson, J. Robinson Enterprises; Daniel Wolf, Service Employees International Union; Woody Richards; Kathie Garrett; Jeremy Pisca, Evans Keane; Rachel Wheatley, Idaho Primary Care Association; Greg Tatham, Bruce Pitman and Stephen Beckley, University of Idaho; Decker Sanders, Office of the State Board of Education; and Ferd Schlapper, Boise State University.

After opening remarks from the Cochairmen, **Represenative Bilbao** moved to approve the minutes from the last meeting. **Senator Cameron** seconded and the minutes were approved unanimously.

Mr. J.P. Weiske, Director, State Affairs, Council for Affordable Health Insurance, was the first speaker. His complete PowerPoint presentation titled *Insuring the Uninsured and the Regulatory Costs of Insurance* is available at the Legislative Services Office. He was introduced to discuss insurance providers trends, reserves, administrative costs and considerations and the implications of competition.

His presentation reviewed state regulation, guaranteed issue, rate review, loss ratio guarantee, reserves, community rating, mandated health review, mandated benefits and state regulation.

He also reviewed the issue of the uninsured and noted that 44.8 million people were uninsured in 2005. He added that 44% of uninsured Americans are eligible for existing programs or have income in excess of 300% of the poverty level. Of the uninsured, 24.7% are eligible for Medicaid or SCHIP, 19.6% have family incomes in excess of 300% of the poverty level and 13% are children eligible for SCHIP.

State efforts to cover the uninsured include bare bones insurance plans, high risk pools, rate reform, pooling arrangements and public-private partnerships. He said that health savings

accounts have been successful at targeting the uninsured and that economic studies of tax credits targeted at the poor could substantially reduce the uninsured rate. Other efforts targeting the uninsured include list billing, underwriting, association insurance, regulatory reform, introduction of single payer plans, reinsurance, connectors, pooling and expansion of SCHIP.

In response to a question from **Senator Werk, Mr. Weiske** explained that loss ratio is the percentage of premium dollars devoted solely to claims. For example, Michigan's loss ratio is 85%; that means that 85% of premiums paid are used only to cover medical claims. The other 15% are used for administrative costs, reserves, salaries, profits, office expenses and so on. This is anything that is involved with the cost of doing business.

Representative Marriot asked what the rationale was for North Dakota to lower their loss ratio to 65%. **Mr. Weiske** said the insurance commissioner felt that the higher loss ratio resulted in less competition. There are very few carriers in North Dakota. He said that it remains to be seen whether this works in attracting other carriers to the area.

Representative Rusche commented that in his experience the cost of health care has accelerated two to three times faster than general inflation but that the ratio of health care costs to administrative expense has stayed pretty much the same. He asked why. **Mr. Weiske** said he is not sure that is the case and has not looked at that information. He did note that there is a vast difference in the types of services offered today than in the past. He said over time some of those administrative expenses have actually been reduced percentagewise.

Mr. Weiske noted that some companies have seen a drop in Health Savings Account (HSA) rates. **Representative Rusche** asked whether part of the reason for that could be due to selection. **Mr. Weiske** said not really. He said that there are findings that older people are actually purchasing HSAs instead of younger people. They are actually five years older on average than other insurance policies across the board.

Senator Goedde asked whether all reserves for health insurance companies come from outside the 85% part of the loss ratio. **Mr. Weiske** said that was essentially true but it is very complicated. **Representative Rusche** commented that in his experience IBNR is considered part of the claims cost and with individual and small group insurance that rolls over each year so there is no reserving for anticipated lifetime costs as would be done with life or disability insurance.

Representative Henbest commented that the information regarding the number of uninsured was inconsistent with what has been found in Idaho. She said information that has been received for Idaho shows a much higher uninsured rate for people who earn less than $25,000 annually. **Mr. Weiske** said his information came from the U.S. Census and noted that every state that has done its own survey has found the U.S. Census numbers wrong or different. He did say these are the only national numbers available. **Representative Rusche** commented that the information could be different because there are a lot fewer households that earn $25,000 or less annually. In Idaho the average household income is about $39,000. He said both answers may actually be

right. The chance of being uninsured if you are low income is a lot higher but there are also less people at that low-income level. **Mr. Weiske** commented that one point about the uninsured is that 33% are probably eligible for some coverage and there needs to be a way to get these people signed up for coverage.

Senator Werk noted that several slides in the presentation give the implication that mandating insurance for private plans causes problems but other information given says more people need to be signed up for government sponsored or subsidized insurance. He said that was confusing and asked for clarification. **Mr. Weiske** said it is really the broader problem of government reimbursement being less.

Representative Rusche asked for information regarding the difference between high risk pools versus reinsurance. **Mr. Weiske** said that high risk pools are programs where people with health conditions sign up with the state and are subsidized through private carriers. These are administered by the states and are only for people with serious health problems. **Representative Rusche** asked whether these are people that are identified beforehand as having a serious medical condition. **Mr. Weiske** said that was correct.

Senator Werk asked for more information on underwriting. **Mr. Weiske** explained that underwriting targets the young by making insurance more affordable and leads to a more affordable and stable health insurance market by creating a healthier pool. He said that medical waivers (or riders) allow individuals with certain medical conditions to obtain standard coverage. **Mr. Weiske** said, in other words, this is a way to adjust for the risk of the more unhealthy people and the cost of those claims. Without this adjustment, rates would have to raised for everyone and that eventually drives the healthy people away.

Senator Cameron asked how it is possible to get around federal mandates with regard to list billing. In his opinion, carriers would not be opposed to list billing as long as those individual products are not required to meet all of the federal guidelines and mandates. **Mr. Weiske** said list billing is meant to be a simplified procedure to target businesses that do not want to offer insurance coverage. He said agents tend to use list billing in hopes of getting an employer to sign up for group coverage later. Some states have appropriate restrictions on list billing such as a requirement that the company has not offered insurance for a period of time. In his opinion, list billing is an appropriate option that should be offered.

Senator Cameron noted that **Mr. Weiske's** brochure says this is a viable alternative and should be addressed. He noted that Idaho requires any employer with more than five employees to offer benefits and there has been opposition to list billing by carriers because they do not want guaranty issue for individual products. He said he is hearing this is a good idea but it is not really practical. **Mr. Weiske** said that list billing is regulated and treated as individual insurance as long as the employer is not providing any insurance. **Senator Cameron** said he would be interested in more information from the 20 states that are doing this.

Senator Cameron asked whether Idaho should expand its high risk pool to include groups. He also asked whether any other state has done this or used a reinsurance pool for this. **Mr. Weiske** said that Connecticut has a small business pool. He said with the advent of HIPAA and guaranteed issue most carriers are reluctant to cede certain risks.

Senator Cameron asked whether there are any standards for reserves or administrative requirements. **Mr. Weiske** answered the only standards he is aware of are related to the financial solvency of the company.

Senator Cameron asked whether the Council for Affordable Health Insurance focuses on any other issues that have an effect on the cost of health care. **Mr. Weiske** said they have done some work looking at hospital rates for the uninsured and underlying health care costs.

Senator Cameron asked what role government should play in health insurance. **Mr. Weiske** said that over time he has seen cost shifting to the private sector. Many doctors have stepped out of the Medicare and Medicaid systems due to the amount of paperwork involved. He said his organization would like to see movement away from expansion of programs like SCHIP. He said this expansion just makes it worse for those in private coverage. He added that people in public coverage do not receive the same level of care as those in private coverage. He said they would like to see a move away from a publicly run system and to try to find ways through subsidies or tax incentives to move people back into the private sector.

Representative Marriott commented that the government has always said it will take care of the poor but in turn makes providers furnish that care at very reduced costs. He asked if any studies have been done on what would happen if government paid usual and customary costs instead of such a reduced amount. **Mr. Weiske** said that no state could afford that and if that were to happen cost shifting would occur and rates would come down. The only way to do this would be to subsidize the coverage rates. He said his organization does not support subsidizing the health insurers, they support subsidizing the people.

Representative Henbest said she is hearing him say that the private marketplace should be used to solve the problem and that the problems are caused by government involvement. On the other hand, the uninsured rates for age groups that have public programs is lower. She asked whether these people would be better off in the private system if those public programs were done away with. **Mr. Weiske** said in comparing the type of care received, people would be better off with private coverage. The average cost of SCHIP per child is $102 and the average cost of other insurance coverage for children is $71. It seems that we are encouraging people to use SCHIP for children's coverage instead of covering on their parents policies and in some cases the system is even encouraging parents to drop their own coverage because kids can be covered by SCHIP. **Representative Henbest** noted that Idaho SCHIP and Medicaid increased the reimbursement rate to match marketplace. She said she has heard a lot of criticism about what states are doing to solve the problem of the uninsured and asked how **Mr. Weiske** would propose dealing in the private marketplace with the uninsured population and affordability. **Mr. Weiske** said his

organization does support the idea of subsidizing people that would never have the ability to afford health insurance. They also support a variety of plan options for individuals, not limiting or defining the type of coverage as well as supporting tax credits, refundable tax credits and list billing. In his opinion there are a host of smaller solutions instead of a big comprehensive solution. **Representative Henbest** commented that his organization supports subsidies for individuals under 100% of poverty and said that in Idaho that population is not covered today except for children. **Mr. Weiske** agreed and said employers are offering coverage and employees are declining because they cannot afford it. He suggested that it might be more affordable to subsidize that coverage through employers instead of having a state plan.

Representative Rusche noted that pediatrics associations are in support of SCHIP.

Representative Block asked how other states fund subsidies. **Mr. Weiske** said that most take it out of general purpose revenue.

Mr. Jack Myers, Executive Vice President, Chief Financial Officer and Dave Hutchins, Vice President, Actuarial Services, Blue Cross of Idaho were introduced to respond to questions that were asked by the Task Force at the last meeting regarding administrative costs, trend and reserves.

Mr. Myers began with a PowerPoint presentation that is available at the Legislative Services Office.

Administrative Costs
He defined administrative costs as all costs associated with developing, marketing and administering products and policies EXCEPT premium tax and broker commissions. Blue Cross' 20 year average administrative cost ratio is 9.30%. He noted that these costs have actually decreased over the last six or seven years. Today the administrative cost ratio is 8.23%.

Mr. Myers explained that causes for administrative cost increases include information system related costs, medical management, regulation (HIPAA, compliance) and government programs. He added that medical claims costs and investment and interest expenses are not included in administrative costs.

Mr. Myers explained that the growth rate of salaries has been lower than the growth rate of total administrative costs. In 1990, salaries represented 54% of total administrative costs and in 2006 salaries were 41%. Executive salaries, like all Blue Cross employee salary increases are based on market-based studies.

In response to a question from **Representative Rusche, Mr. Myers** explained that their per member per month costs have increased from $14.81 to $18.46 in the most recent five year period or about a 5% increase.

Senator Cameron asked what the administrative costs were in 1990 versus 2006. **Mr. Myers** said that in 1990 those costs were $15.5 million and in 2006 they were $89.4 million.

Senator Cameron commented that executive salaries are based on market-based studies and asked for an idea of what those salary increases have been. **Mr. Myers** said about 3.5% to 4% or slightly higher overall.

Representative Henbest asked what is included in administrative costs. **Mr. Myers** said the only thing excluded would be commissions. Representative Henbest clarified that would include bonuses, education, travel and the like. **Mr. Myers** agreed.

Trend

Mr. Hutchins explained that trend is defined as the increase in claim costs over time. When talking about trend it can mean experienced trend (how much it will be increased) or projected trend (how much it will increase in the future). There is also product trend, company trend and national trend.

He said that with national trend it is important to pick a relevant number. There are problems with CPI and employer cost. Regional/local trend will differ from national trend due to local conditions such as local medical practices and technology adoption and local mergers of providers.

Mr. Hutchins went on to answer the question of whether claims are loaded multiple times. He used the following example:

- The law states that the rates for an individual cannot go up more than the rates for the pool plus 15%, plus any age increase.
- Let's say Person A has a $500,000 claim. Person A may get a 15% increase in premium due to experience, the maximum allowed by law. Let's say that works out to $500 per year ($41.67 per month).
- Pool rate reflects the remaining $499,500 in claim cost, so Person A's rate also includes this cost. If the cost is spread out evenly among 50,000 people in the pool, that works out to $9.99 per year ($0.83 per month).
- The concern is that the $9.99 takes the full increase for that person due to his claim up more than 15%.
- While it is true that Person A's costs are 15.3% higher than they would have been if Person A had never had the claim, the premium change for Person A complies with the law, because it went up only 15% more than the pool rate.
- Any formula adjusting for this effect would be very complicated and have very little effect.
- BCI's rate formulas are careful to base the pool increase on only the $499,500 amount.

Mr. Hutchins stated that there are two questions to be considered when deciding whether previously underestimated trends should come from reserves or increase premiums. Those

questions are:

- Should losses generated due to underestimated trends be recovered?

He said that an insurance company with solvency problems will have to make up the losses in premiums. On the other hand, an insurance company in good financial shape is likely to absorb past losses in its reserves. Otherwise it is forced to try to market uncompetitive rates.

- If an insurer underestimates trends in one period, should the rates the next period be based on the underestimated trend, or the experienced trend?

Mr. Hutchins said the answer to this is no because the new rates would be insufficient. Companies may choose to catch up with underrated products slowly in order to reduce marketplace shock. This strategy rarely works.

He gave the following example of rate catch up.

Rate – Year 1	**$100**
Costs – Year 1	**110**
Year 1 Underrated by	**$ 10**

Year 2 Rate Should Be:	
Costs – Year 1	**$110**
+ 10% Trend	**11**
	$121

A 21% rate increase in year 2 raises the rate to a level expected to cover costs in Year 2 but does not recover the $10 loss in Year 1.

Their presentation also includes a graph showing expected versus actual versus nongroup cost trend. **Representative Rusche** asked what happened to cause the increases in trend they have seen over the last few months. **Mr. Hutchins** said there was a surprising dearth of large claims. As soon as the large claims went away, trend went down and they dropped premiums. Once they did that, the number of claims jumped up again. He said Blue Cross has about 50,000 members in individual coverage and this would be an unusual occurrence. **Mr. Myers** said at that time they were experiencing significant growth in the individual and nongroup pools. **Representative Rusche** asked whether these were new enrollees that were recently underwritten into the pool. **Mr. Myers** said that was correct. **Representative Henbest** asked if they were to overlay enrollment with the dropped premiums period in August of 2006, what would enrollment look like. **Mr. Hutchins** said they had good climbing enrollment up to when the premium was dropped and it has dropped off since then.

Senator Cameron commented that May and June 2007 show increases just under a 23% baseline. He said that does not take into account individual case characteristics or individual claims. He said some individuals are receiving 40% to 45% increases. **Mr. Hutchins** said Blue Cross has not given a pool increase that reflects the full 24% increase. Some customers will be receiving a 20% increase in premiums. **Senator Cameron** commented that over the last 18

months this product was not being blended with other product lines so he would assume there were other product lines that took more substantial increases. **Mr. Hutchins** explained that there were different increases due to the fact that PPO plans were not reflecting the full provider value of provider discounts. Changing rates to bring them in line did cause a great increase to individual rates.

Reserves

Mr. Myers explained that the goals of reserves are to:

- Provide financial stability.
- Assure policyholders and providers that BCI will be able to pay present and future claims.
- Provide greater stability in premium rate changes.
- Protect against catastrophic loss.
- Provide for capital investment in information technology, other capital projects and business development.

He stated that Blue Cross of Idaho has determined that it should achieve long-range underwriting gains of 2% to 3% of premium revenues in order to maintain or slightly increase the reserves to risk ratio. The most common method of measuring reserves is Risk Based Capital (RBC). He said that all insurance companies file an RBC based report with the Department of Insurance.

Mr. Myers included a chart showing RBC and said it defines a minimum level of reserves that a health plan should have. It has been adopted by the Association of Insurance Commissioners and by most states. The purpose is to make sure that reserves are adequate and it looks at a variety of risks that any company would have. The predominate risk area for insurance is underwriting risk. He said that they look at the past 18 months and try to predict what the future will hold.

The Department of Insurance (DOI) has a minimum level of 100% risk-based capital ratio. At that point, the DOI is authorized to come in and help the company operate. He said that the Blue Cross/Blue Shield Association has somewhat higher standards because of the interdependence on providing services in other states. These are set at about 500% and anything below that the Association begins monitoring. **Mr. Myer** said that Blue Cross of Idaho's RBC is between 700% and 800%. This is saying their reserves are 747% of the authorized level of 100%.

Senator Corder asked in the last 10 years how many times have they had underwriting losses. **Mr. Myers** said in five of last twenty years BCI has had underwriting losses. He said that does not mean that they have not underestimated in other years.

Representative Rusche asked whether their RBC includes the State of Idaho account. **Mr. Myers** said yes.

Representative Henbest asked if BCI took state employees out, what would this look like. **Mr. Myers** said he was not sure, the State of Idaho account still proposes some risk to BCI and they have a 10% reserve requirement. A level of underwriting risk would go away but none of the

reserve requirements would change so the RBC would look pretty much the same.

In response to another question from **Representative Henbest** regarding the Blue Cross/Blue Shield Association, **Mr. Myer** explained that the association wants to guard against any of its plans running into trouble so it starts monitoring before the Department of Insurance would.

Senator Cameron asked for more explanation of their RBC level being 747% higher than mandatory authorized reserve. **Mr. Myer** said that the 100% authorized control level is equal to $10 million. If this is the case, having a 747% level means their capital level is at $74 million.

In response to another question from **Senator Cameron, Mr. Myers** explained that regulatory control is to make sure there are adequate reserves. Risk-based capital is intended to be the minimum capital necessary. **Senator Cameron** clarified that the association recommends companies be at 500% of authorized level. **Mr. Myers** said that was not correct. He explained that once companies in the Blue Cross/Blue Shield Association go below 500%, they will be monitored. He noted that the association does not have recommended levels of reserves that companies should hold. It is understood that each plan is individual and has different characteristics.

Senator Stegner asked about the difference between company action and regulatory action. **Mr. Myers** explained that a company action and regulatory action is a statement of a problem and a corrective action plan. There is monitoring of the plan to make sure reserve levels are increasing as necessary. Authorized control gives the DOI authority to go into the company and actually work with them to get reserves back up.

Mr. Myers stated that BCI does not raise its rates to catch up for a loss. Rate increases only bring rates to a level to cover costs and a small underwriting gain. **Senator Cameron** said it was mentioned at another meeting that since trend had been underestimated, premiums were being loaded to make up for the difference as well as for projecting forward. **Mr. Myers** said that was very complicated and referred to the above example of rate catch-up on page 7 of these minutes. He said there is a difference between catching up due to missed trend and building that into future rates and catching up on an underwriting loss.

Senator Stegner asked what justifies increasing the premium to $110 assuming it has been $100 for some time. He pointed out that raising the second year rate to $110 suggests that they are attempting to pick up past losses. **Mr. Myers** said BCI does not recover losses going forward. **Senator Stegner** asked whether they have taken money out of reserves to pay for losses. **Mr. Myers** said losses did reduce reserves.

Senator Cameron commented that regarding BCIs actual reserves, the last few years have seen fairly flat increases. He noted that in 2003 it looks like there was a significant increase in reserves by the company. He said this is a significant uptake in reserves and in his opinion this is not all due to the fact that the company is having lower losses. He noted that consumers are also

being asked to pay more in premiums. It would seem to him that if they are building that much reserve, they are overcharging for premiums. **Senator Cameron** asked whether reserves should not be held flat with this significant uptake. **Mr. Myers** explained that the significant increase in reserves is attributable to a significant increase in members, that adds risk. He added that health care costs trends have been in double digits until recently. He said they were surprised when the trend started to drop and this did increase reserves by more than expected. In answer to that, BCI reduced rates in 2003 in some areas and reduced the rate of increase in some areas. At the same time health care costs were increasing and that is what is causing today's rate increases.

Senator Werk asked whether BCI's federal income tax liability was overall tax liability and deducting firm investments. **Mr. Myers** said that was correct, the total federal income tax was on overall operations.

Mr. Myers noted that reserves declined in 1987, 1988, 1996, 1998 and 1999 for a total of $23.3 million. He said that all declines were due to underwriting loss, offset somewhat by investment gains.

Mr. Laren Walker, AmeriBen Solutions was introduced to give an update of the state high risk pool. He explained that the high risk pool was established in 2000 and the intention was to provide availability of insurance to individuals rated either too high by insurance companies or those who were not offered insurance by carriers.

Mr. Walker distributed a balance sheet of the high risk pool for June 30, 2006 and 2007. This information is available in the Legislative Services Office and also from the Department of Insurance and shows $14,985,796 deferred state tax funds that have not been used by the program. These fund have come from the premium tax dollars.

His handout also included an income statement of the program for the first half of 2007. Premium dollars paid by carriers accrue at about $200,000 per month. **Mr. Walker** explained that this is the first component of revenue to the high risk pool. The second component is the premium tax dollars, and the third, if need be, is an assessment to the carriers. He noted that this third component has not been necessary. The revenues in this statement only come from the carriers with investment gains and losses.

Mr. Walker said that expenditures, as would be expected, are the largest component. These are the claims incurred by the program. Year to date there have been $2 million in claims.

His handout shows that there have been 1,395 lives in the high risk pool through July 20, 2007, and provides a breakdown of ceded lives in the high risk pool by carriers. It also shows activity by plan type (Basic, Standard, Catastrophic A, Catastrophic B and Health Savings Account (HSA)and Health Savings Account (HSA) non-smoker).

In response to a question from **Represenative Bilbao, Mr. Walker** explained that the high risk

pool is not really an insurance company. He said that insurance carriers pay into the pool to cede people into it.

Mr. Walker said he would provide information on premium prices for the various plans for the individual at a later date as well as a description of each plan. He added that he would also distribute the list of large claims (over $50,000) that has been provided in the past.

Tim Olson, Vice President, Corporate Affairs and Jim Pinkerton, Manager of Actuarial Policy, Regence/Blue Shield spoke to the task force in response to the same questions that Blue Cross covered earlier. The questions asked pertain to three aspects of the business of insurance: reserves, administrative costs and trend. **Mr. Olson** noted that from the presentation given earlier by Blue Cross, even though they are much larger than Regence, it is apparent that the percentages in terms of administrative costs and reserves are similar. He said he could provide those specific numbers for comparison at a later date.

Mr. Olson listed the following factors that increase health care costs.

- Aging population
- Changes in prescription drugs
- Provider reimbursement needs
- Provider practices and referral patterns
- Higher utilization of services (including preventative treatment)
- Cost shifting from state and federal government
- Diseases driven by poor nutrition and inactivity
- Cost of IT systems
- Development systems where providers and health plans exchange medical information quickly and securely

Mr. Pinkerton commented that Regence is committed to working to remove complexity within the health care industry; however, certain components such as these are very much a part of the current system and will likely always present in some form.

Reserves

Mr. Pinkerton explained that reserves help Regence meet obligations to members and support their health care needs today and in the future. As a not-for-profit company, they do not have shareholders to whom they are obligated to pay dividends. He said that Regence maintains reserves solely to guarantee adequate funds to pay member claims in the face of catastrophic events or unexpected claims volume as required by regulators.

Regence measures reserves using the risk-based capital Model Commitment Law. **Mr. Pinkerton** said the RBC is a more sophisticated measurement than a ratio and was designed by regulators as an early warning system for carriers moving toward solvency problems.

Mr. Pinkerton noted that they did not have permission to share information with other Blue

Plans so could not answer the question of how their reserves compare to other Blue Plans.

Regence's 2006 reserve level equates to approximately $700 per member or $58.00 per month.

He stated that investment income goes to reserves and is reinvested.

Senator Goedde said he would like to see Regence's RBC ratios over the last ten years.

Senator Cameron asked where Regence would be compared to Blue Cross in terms of surplus above the required RBC. **Mr. Pinkerton** said they would be at about 1,300%.

In response to another question from **Senator Cameron**, **Mr. Pinkerton** said he would get information for the task force showing their reserves and the contributions made into those reserves for the last few years. His assumption is that those reserves would be lower about 18 to 24 months ago and should have since been building back up. **Senator Cameron** asked to what extent does the state of Idaho account affect other policies sold in the marketplace with reserves and such. **Mr. Pinkerton** said when Regence lost that account it did affect them dramatically.

Administrative Costs
Administrative cost is divided into two major categories; claims adjustment expense and general administration expense. **Mr. Pinkerton** said the claims adjustment is basically expenses incurred to record, adjust and settle claims. In 2004 this was broadened to include cost containment expenses. General administration expense is any indirect cost relative to normal company operations. He said the results for how their administrative costs compare to last year will not be available until the fiscal year is complete.

Mr. Pinkerton said that rising claims costs, not administrative expenses, drive premium. Premium costs are driven primarily by use of medical services, new medical technology, rising drug costs and increases in chronic disease and the aging population. Claims paid are not included in administrative costs.

He noted that salaries have remained approximately 49% of overall administrative costs for several years. Regence is committed to providing competitive salaries while effectively managing administrative costs. Compensation is based on salary comparisons with the industry and other companies of similar size.

Trend
Trend is the year-over-year change in per-member claims expenses for large populations. National trend is a very high-level look and is, at best, a rule of thumb. Trend experiences at the company and product level are the result of many factors and may vary from company to company in a similar region. Some factors that may influence trend at a micro level are provider contracting, mix of business and utilization practices of members.

Mr. Pinkerton said it is not their company practice to count claims more than once. He went on to say that underestimated trend results in inadequate rates. The carrier is obligated to adjudicate claims in a timely manner whether the rates are adequate or not, resulting in the claims being paid before the rates are adjusted. He said there are numerous influences that affect trend such as products and the diversity of the people insured. The most accurate way to assess trend is to review underwriting results.

Senator Cameron commented that the national trend is 8% to 12%, but he is not seeing any medical providers raising their rates by that much. He is assuming that national trend is being influenced by utilization that is calculated into the medical provider increases. He said he is having a hard time understanding the rate increases of 24% that are being seen in Idaho. **Mr. Pinkerton** said in the beginning the rates do not reflect utilization. Often trend numbers that come from brokerage firms are surveys of premium increases. He said rates are set to be adequate for the rating period being anticipated based on an estimate of claims for that same period. Until that point, premium is not looked at because it is irrelevant.

Senator Cameron said this gives an inference that there is a compound factor that applies toward establishing trend. It seems to him that a portion of the same claims that are used to calculate the first trend line are used to calculate the medium size group rate and then those medium size employers' rates are adjusted according to how well they fared within that pool and weighted. He asked how this is not factoring in the same claims three times in deciding on the overall rate increase. **Mr. Pinkerton** said it would be simpler to walk through Regence's rating process. He said in the rating process the first thing is to look at the pool that is being worked on; individual for example. Claim analysis is done on that pool. He said in the companies he has worked for, national trend has never been looked at as anything other than a point of interest. Most companies look at their pool of business and the trend they are observing. Then factors that may influence that trend are considered. Some of those factors might be economic conditions, legislative actions, shift in products and so on. He said that trend is established for the specific pool and then claims are looked at. Trend is then applied to those claims and that would be the projected claims for a specific time period in the future. He said that is usually 18 months. On top of that administrative costs would be projected separately.

Mr. Pinkerton said that the next rate increases are set for any specific group including factors that apply to that small group or pool. He said you build the factors so the pool is revenue neutral with the amount of money planned to be generated. He said he does not see any claim being counted more than once. **Mr. Olson** said they would be happy to come back with a more specific presentation on this at another meeting.

Mr. Decker Sanders, Interim Chief Post Secondary Academic Officer, Idaho State Board of Education was the next speaker. He was introduced to give a brief historical perspective on the Board's development and implementation of policy concerning Student Health Insurance at colleges and universities.

He explained that the Board first expressed interest in developing a mandatory policy on Student Health Insurance for colleges and universities in January 2000. Board staff worked with representatives from the affected institutions to draft policy which was presented to the Board at their March 2002 meeting and then adopted in April. The policy became effective on July 1, 2003.

This policy affects each of the four year institutions (BSU, ISU, U of I and LCSC) as well as the Eastern Idaho Technical College (EITC). Private educational institutions in Idaho and community colleges are not required to adhere to the policy.

The policy provides the minimum direction to institutions on student health insurance and each institution may adopt a policy that is more stringent. He said the institutions are encouraged to work together to provide the most cost-effective coverage possible. Health insurance offered shall provide benefits in accordance with state and federal law.

Institutions must offer "full fee paying" students the option to purchase health insurance. The institutions may allow a student to present evidence of health care coverage that is at least substantially equivalent to the health insurance coverage offered through the institution.

The policy is enforceable in those institutions that may deny enrollment or terminate registration of students found to be in violation of the policy. Generally, students whose registration is terminated are allowed to be reinstated once the student is in compliance with the policy.

Senator Lodge asked whether families can be covered through student health insurance. **Mr. Decker** said most institutions have that as an option to add at an increased premium. **Senator Lodge** asked about the costs/rates and whether they done by semester. **Mr. Decker** said it varies because different institutions use different carriers.

Representative Rusche asked regarding those students who are disenrolled for failure to have coverage whether there is an assistance program that would allow them to stay in school. **Mr. Decker** said he is not aware of anything.

Senator Cameron commented that the board adopted the policy in 2002 and asked whether the board has revisited the policy or given universities any updates or further instructions. **Mr. Decker** said there was a study in 2005 looking at what the option might look like using a statewide pool of university students. The outcome did not show any significant savings. **Senator Cameron** said he would like to see that study.

Senator Cameron said it is his understanding that the directive from the Board is that each student is required to have coverage. He asked whether the board has defined what coverage should look like or whether it is open-ended. **Mr. Decker** said that full fee paying students must have coverage that complies with state and federal law, the rest is left up to the universities and carriers.

In response to a question from **Representative Wood** regarding the actual experience of students denied or disenrolled for failure to have appropriate insurance, **Mr. Decker** said he did not have those numbers. He said the Board only hears about that if a student appeals.

The next presenters were **Greg Tatham, Student Health Insurance Director, Bruce Pitman, Vice President of Student Affairs, University of Idaho and Steve Beckley, Consultant for the University of Idaho** for further discussion of student health insurance.

Mr. Tatham noted that he did not think the U of I has had any students disenrolled due to lack of health insurance. The most common situation is that a student is discovered to be uninsured during the year and arrangements are made to get them enrolled. He said that more often than not due to the expense of coverage, parents and students are anxious to enroll in the program because it provides good benefits at lower costs.

Senator Cameron asked for information on how they determined what their plan would look like. **Mr. Beckley** said his firm did a major review of the student health program in 2000 that resulted in a major redesign of the program that just happened to coincide with the Board's policy requiring health insurance. Their review recommended that health insurance should be provided because it found that 20% of the students were uninsured. The parameters of the plan in a nutshell are that students should be able to rely on the program for their sole source of health insurance. This leads to catastrophic coverage. The plan has a $1 million lifetime maximum and no preexisting conditions exclusion, it has adequate prescription drug coverage, and first dollar mental health care coverage. He said he would feel comfortable if his children had this coverage. **Mr. Beckley** said they did not want this health plan to duplicate student's private insurance. **Mr. Pitman** said there were a certain set of services that were thought to be essential and one of those was psychiatric care.

In response to a question from **Representative Marriott,** it was explained that primary care services are provided on campus by Moscow Family Medicine. Students in other areas have different clinics they can visit.

In response to a question from **Senator Goedde,** it was stated that this program was strongly supported by Latah county and has helped with their indigent care costs due to the large number of uninsured in the late 1990s.

Mr. Beckley explained that family members that are covered do not have access to the health center or the counseling center so that is a factor in their claim consumption. He noted that pregnancy claims are often significant and then it is a question of each school's management committee of how much they want to subsidize the coverage for the single student. He noted that the spring semester fee covers the student for the summer as well.

In response to a question from **Senator Stegner,** it was stated that hospitals and care providers in the area have been extremely supportive of the program.

University of Idaho had about 2,800 students enrolled that participated in the health insurance plan last year and are expecting about that many this year. There are about 10,500 total enrollees in the University.

Senator Lodge asked whether allowing students to stay on their parent's policy until age 25 will affect this program's enrollment. **Mr. Beckley** said that has not been the case in other states that allow it. They have seen a 40% increase in the number of undergraduates since this program was been implemented in 2002.

Senator Lodge asked how many spouses are covered. The answer was about 100 and about 50 children. **Representative Collins** said he would like information regarding the number of students that are remaining on their parents insurance as well.

Eric Milstead, Legislative Services Office introduced **Mr. Ferd Schlapper, Executive Director of the Health and Wellness Center and Katie McGrath, Maksin Group, Boise State University, Andrew Hanson, Dean of Student Services, Lewis Clark State College, Terry Lyons, Academic Health Plan and Crystal Ross, Idaho State University, representatives from United Healthcare Student Resources, University of Idaho** for more discussion of student health insurance.

Mr. Ferd Schlapper spoke to some of the questions that had been asked earlier. He commented that this trend toward mandatory health insurance requirements for students is a national trend in all states and university systems. He said he is not aware of an example going away from this requirement. One reason for this is so community health care providers can make sure they have adequate coverage for service providers. The other need for this insurance coverage is a safety net for students for existing health care costs and how to best meet those needs so that someone's academic career is not derailed by illness or injury. Overwhelmingly, throughout the country it has been found that a voluntary system becomes a death spiral. This means that students only sign up when they know they need services which leads to more use and higher claims. This leads to higher premiums and fewer and fewer students can afford it. The plan ends up with very limited benefits and very high premiums and low enrollment.

Mr. Schlapper said in his opinion there are ways to bring costs down. He said there are states that have overcome the challenges involved in having a statewide consortium to pool all of the risk among all schools. He thinks this should be revisited and noted that the University of Georgia with 37 schools has been able to pool within one consortium with 20% savings in their premiums.

Another cost savings involved primary care. He said if students receive their primary care on campus before going into the community for specialty care, it is much more cost effective. The Blues in Minnesota did a study that showed a 30% savings with this.

He said that BSU is looking at, instead of filing claims, to have everything be a part of a

capitation fee to save on administrative expenses of processing those claims.

Another possibility is the possibility of a self-insurance fund.

Senator Lodge asked whether private schools were included in the Georgia consortium. **Mr. Schlapper** said he thinks it was just public institutions. He said he was not sure about community colleges but since Georgia Tech was included, he would assume other technical colleges were also included.

Representative Collins asked what was behind the idea of the State Board of Education not including junior colleges or technical schools in this. **Mr. Decker** said because they are not governed by the Board of Education. He said it could be worked out to include those groups.

Senator Goedde asked what amount of enrollment is required to mandate coverage. **Mr. Schlapper** said BSU has 4,700 students in the plan and it is required if enrolled in 8 credits or more. **Mr. Hanson** said that LCSC requires coverage at 8 credits also.

Senator Stegner commented that U of I did not detect any students that were disenrolled or unable to enroll because of health care costs. He asked LSCS if this had happened and if so, is it more prevalent in the technical school versus the academic portions. **Mr. Schlapper** said that BSU, similar to U of I, is not aware of anyone withdrawing. He explained that BSU automatically enrolls anyone who has more than 8 credits and the fee is automatically included in their tuition. If they show a waiver of other insurance, that fee is removed from their tuition.

Mr. Hanson, said when LCSC first started the program, they thought they would see more students dropping or not enrolling than they actually did. He has only actually heard two students saying health insurance costs were the absolute reason for not enrolling.

Senator Werk asked whether the other colleges and university plans have similar benefit profiles to the U of I. **Mr. Schlapper** said he could forward such an outline to members and that is was also online. In his opinion the parameters of BSU's plan are comparable to U of I. He added that a survey of students asking what type of coverage is most important ranked more comprehensive benefits and more affordable premiums at the top.

Mr. Schlapper said BSU does offer primary care services on campus. They are building a new facility on campus that will expand staff and care provided. He said students struggle most with underlying health issues that often are not identified so caring for minor issues often helps identify these.

Senator Werk suggested that the Legislative Services Office put together a chart of all of the plans to compare costs and benefits. **Mr. Decker Sanders** said he would prepare that chart.

Mr. Hanson echoed what BSU said. He said he was not familiar with the U of I plan but it is

more comprehensive. He said he would send a copy of LCSC's plan to the committee.

Representative Rusche asked whether part-time students can be eligible to participate in this coverage. **Mr. Schlapper** said no because that would make it a voluntary plan and voluntary coverage always increases the costs of claims.

Senator Goedde commented that there seemed to be an inequity in making the professional-technical students at the U of I, BSU and LCSC subject to these costs but not so with other community colleges.

In response to a question from **Senator Cameron, Mr. Schlapper** said BSU's coverage is a full 12 months coverage including summer. The spring semester includes summer. The reason for this is that the State Board requires tuition be the same for both fall and spring semester so they could not adjust for fall/spring-summer. LCSC does their coverage the same way.

Senator Cameron asked what the lifetime maximums were for the other schools; BSU is $100,000 but that is annually and can be added on to increase it up to $500,000. LCSC is $250,000 maximum.

Mr. Terry Lyons and Ms. Crystal Ross, Idaho State University spoke that the cost for insurance at ISU is $1,000 per year with a $50,000 per injury or illness maximum with the option for the student to increase that to $150,000 per injury or sickness. This does not cover intercollegiate sports injuries. Athletes are insured under a separate policy and the school pays that premium to cover sports injuries that occur while participating in the sport. Athletes are covered under the student coverage for other injuries. Athletic coverage is $200,000 annually and is group rated for all athletes. The student plan does not include a prescription drug benefit but students can get drugs at the student health center at reduced costs.

She noted that they have seen enrollment dropping with students looking for other options to buy cheaper coverage. Raising the age limit to 25 years does give students an option.

Senator Lodge asked whether graduate students were included. **Ms. Ross** said yes. She added that premiums for dependents are quite expensive.

The next meeting was tentatively scheduled for September 24 and with no further business the meeting was adjourned at 4:00 p.m.